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Practicing on Newly Dead Bodies

by Robert D. Orr, MD

Medical students and resident physicians need to absorb and learn an awful lot of information from books, lectures, and practical interaction with live patients. In addition to the gaining of knowledge, they must also become proficient at many technical procedures. Some of those procedures are important, but not a matter of life and death. These procedures may be learned methodically at a pace appropriate to the procedure and the individual. They may even be learned by trial and error! For instance, a medical student may make an error in performing an electrocardiogram, such as switching the placement of the limb leads, without causing any danger to the patient—only the inconvenience of having to have the procedure repeated.

However, some of the procedures which must be mastered are life-saving. Students and residents must learn them quickly and expertly so that, when they become practicing physicians, they will be able to perform them accurately and with confidence. Examples include endotracheal intubation, placement of central venous lines, insertion of drainage tubes into the chest, or needles into the heart, etc. And once learned, it is important for trainees and physicians alike to maintain proficiency in them. If they do not perform them frequently, but will be in clinical situations where they must be able to perform them at a moment's notice, they must somehow practice to retain their skill.

How are trainees to become adept at such procedures? One suggestion—a suggestion which has been used at some institutions—is that the trainees practice on newly dead bodies. When a patient dies, before the body is taken from the emergency room, intensive care unit, or even the hospital ward, it is possible for several students to practice procedures for a few minutes. Such practice offers advantages over practice on mannequins—the anatomy is accurate and realistic. It also offers advantages over practicing on preserved cadavers—the tissue tone remains normal for a few hours after death. And such practice is usually better than practice on anesthetized animals, again because of anatomical correctness.

If the answer to the pragmatic question is that practicing on newly dead bodies would be the best way for trainees to learn procedures, the ethical question becomes should it be done? Would this be showing disrespect to the dead? If it is to be done, is it necessary to obtain consent? And if it is done without consent, would this be considered assault on a corpse? If it is done without consent, should the practice be kept secret so that the public does not become upset with or come to mistrust the medical profession? If consent is necessary, from whom should it be obtained? Who has authority over the dead body? Should consent be sought from family members? Would requesting consent be too emotionally difficult for the recently bereaved?

Not everyone in medicine or medical ethics agrees on the answers to these questions. Some feel it is appropriate and even vitally necessary. Others believe it is permissible only with consent. Still others believe that those procedures which do not change the appearance of the corpse (such as endotracheal intubation) are okay, but those which leave tell-tale marks (such as the insertion of needles or tubes) should not be done.

We have invited comments from two individuals who have thoughtfully addressed this issue and have come up with different answers—individuals who have gained national reputations for taking clear positions on the issue of practicing on newly dead bodies.

Save the Dates
March 1 & 2, 1998
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Spirituality and Medical Ethics

Life versus Death: The Ethical Imperative to Practice and Teach Using the Newly Dead

Kenneth V. Iserson, MD, MBA, FACEP

Presented at the Loma Linda University Bioethics Grand Rounds on September 27, 1995.

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In the Brothers Grimm version of the classic fairy tale, Little Red Riding Hood ventures into the forest where she meets the Big Bad Wolf. The Wolf, in disguise, seems kindly, initially lulling Little Red Riding Hood into a false sense of security. Not having had to deal with wolves before, Little Red Riding Hood scarcely understands her situation, let alone the danger she is in.

Little Red Riding Hood ventured into trouble when she mistook the Big Bad Wolf for her kindly grandmother. We dare not make an analogous mistake in medicine or in bioethics—confusing good appearances with real and practical benefits for all of society. Unlike Little Red Riding Hood, mistaking what we see for what we want to see can prove fatal—not for us, but for our patients. Like Little Red Riding Hood, though, we need to look through the disguise of misapplied "ethical principles" to see where the truth lies.

The Knowledge Base

Good ethics begins with good information—in policy development as well as in clinical consultations. In regard to discussing postmortem practice and teaching, the information comes in two parts: the setting in which clinicians use lifesaving skills, such as intubation; and what happens to corpses, both in the hospital and elsewhere. If sought, clinical ethicists can easily obtain the former information from their colleagues in emergency and intensive care medicine, and from paramedics in their emergency medical system. While they might not themselves experience the dread of not passing a tube into the trachea of a dying child, or having to reach for the scalpel to cut a surgical airway when their skills at intubation failed, they can certainly vicariously feel these experiences. They can view the patient's neck with a fresh cricothyrotomy scar, or visit the morgue and see those in whom the clinicians could not obtain an airway (or maybe watch the television show "ER").

The second important piece of information necessary for rational policy development is what can and does happen to corpses. Clinical ethicists can easily determine what happens to corpses in and just after they leave the emergency department, intensive care units, or wards. As some bioethicists belatedly discovered after promoting an intrusive policy requiring informed consent before practicing and teaching on cadavers could occur, cadavers do not idly lie around in busy hospital beds. Rather, nurses or in-house morticians quickly whisk them to the morgue, so valuable bed space can be opened. Perhaps they should have asked; it's the same in every hospital in the nation.

No public outcry has demanded that clinicians stop using the newly dead in this manner; it is only misguided ethicists. One recent situation may be instructive in this matter. The U.S. media publicized an exposé in Germany that cadavers were being used as crash dummies, and then tried to create public outrage that the same practice was occurring in the U.S. The public, informed that cadaver studies were saving lives through innovations in automobile safety, showed no concern, even though the source of many of the cadavers used is uncertain.

The Corpse As A Symbol

Despite all this, societies should respect their dead; it remains the mark of a civilized society. Respect is due because the newly dead corpse symbolizes the recently deceased person, as well as all of humanity. Yet to what extent must we pay homage to the symbol? Respecting the symbol by denying physicians the skills to keep the living from joining the dead is, as Feinberg says, "a poor sort of 'respect' to show a sacred symbol."

Another way of viewing this situation is to see postmortem practice as the ultimate respect for the corpse. The clinicians who worked to save a person's life (and failed) now will use that person's shell to hone skills with

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which they will try to save their next critical patient. Anyone who has seen this practice knows that it is done with respect—some would say awe. If respect means paying homage, showing deference, and bestowing honor, this procedure is more respectful than many of the after-death rites in our society, such as embalming.

The main question is whether the living, in the person of the next patient needing the health professional's critical life-saving skills to survive, should be sacrificed to the memory of the dead. As I understand it, human sacrifice was banned in Western religious practice in Biblical times [Genesis 22]. It would be a travesty to reverse this noble advance for civilization under the guise of "bioethics."

Skills and Societal Expectations

Imagine for a minute that you are traveling in a commercial airliner when the captain comes on and informs the passengers that, unfortunately, both he and the copilot have neither flown nor been in a trainer for the past six months, having just returned from a wonderful prolonged vacation in Tahiti. "Don't worry," he says. "It's just like riding a bike." Think about how reassured you would be. Flying a commercial jet is not like "riding a bike," and neither is placing an endotracheal tube or a central venous catheter in a dying patient. In both circumstances new and unexpected problems occur, variations from the norm exist, and equipment changes over time. Unfortunately, unlike most commercial pilots, not all clinicians needing to perform these procedures had exhaustive training to make them even initially proficient. Yet their skill level will be what saves (or loses) lives. Those who excel at these procedures need to teach others and remain proficient themselves.

Requiring clinicians formally to request permission before practicing these life-saving skills guarantees that many of them will simply either not ask and not practice (putting many lives in jeopardy) or practice without asking (placing other bioethics policies and any respect for bioethicists in harm's way). Putting any barriers in the way of maintaining these skills does a disservice to all patients relying on these clinicians to save or maintain their lives.

Autonomy—An Artificial Barrier

The basis for requesting consent to practice or teach on the newly dead stems from the mistaken assumption that autonomy survives death, or that the "quasi-property" rights over the corpse given to next-of-kin allow them to disallow non-disfiguring practice and teaching. Neither is true.

Patient autonomy and the associated process of informed consent derives from the respect individuals are shown by others. Simple as the concept is, corpses no longer are individuals and cannot be the basis for either autonomy or informed consent. They are merely symbols. As Callahan said, maintaining that any harm or wrong can come to the dead is "legal fiction." In a similar way, it appears to be "ethical fiction," a preposterous extension of an ethical principle far beyond its meaning or usefulness. One might wonder whether it might not be useful to first extend the practice of respecting individual patients and their autonomy to the clinical setting, where experience shows it has yet to be accepted by the vast majority of clinicians.

The question however, arises: what about cultural sensitivity, especially in groups who disallow manipulation of the dead? One group often cited is Orthodox Jews (although Native Americans and other groups also have similar beliefs). In fact, Israel's Chief Rabbinate recently ruled that practicing endotracheal intubation on the newly deceased is allowable, specifically because other identifiable persons will be saved. Which others? The "others" are the next patients in respiratory arrest or distress coming through the doors of the emergency department.

A Communitarian Ethic and Emergency Care

Although Americans only reluctantly admit it, we exist in a community of others not too dissimilar to ourselves. We access the services this community provides and owe a duty to our cocommunitarians to perpetuate and improve the best of these services. Dialing 911 to get emergency help is just such an outstanding community-provided service. Most of the time, those accessing the system go to the emergency department, are treated, and eventually go home. Some, however, die despite the best efforts of the emergency medical team. When this happens, those who have used their skills attempting to save the patient's life have a responsibility to the community to pass on these skills to other members of the team, to ensure that their skills remain proficient, and to upgrade their skill levels. The patient implicitly agreed to this practice and teaching not only by using the services of emergency medical personnel, but also by merely living in our society, which provides everyone a right to this care.

Unlike other methods of entering into research or teaching protocols, temporarily becoming an emergency department teaching cadaver describes one of our society's most egalitarian systems. No one knows who will be the next to exit life in the emergency department's resuscitation room. The person will be, however, someone who at least temporarily existed within the ED's catchment area, and is very likely to be similar to both the last dead patient (from whom some providers learned how to do life-saving procedures) and the next dying patient (for whom some providers will use skills they learn from this cadaver). With a generalized policy of practice and teaching, neither rich nor poor, young nor old, black nor white will be over-represented among the educational cadavers—they will simply parallel the population seen in an ED by a particular group of providers.

The communitarian ethic now successfully thrives and demonstrably serves society in other Western medical cultures. Yet, some will not agree that Americans should be bound by a communitarian ethic, preferring to champion individuality, especially differences in religious and cultural beliefs that may not condone manipulation of the cadaver. Respect for religious beliefs remains a basic tenet that ties our nation together. In many cases, however, these religious traditions are malleable, based on the realistic needs of co-religionists. In other instances, cadaveric integrity is often (sometimes unknowingly) violated during the mutilating

processes of "restoration" and embalming. A question we must answer as a society, then, is whether individuals can benefit from societal goods (such as resuscitation) and simultaneously not contribute to this good (by lending one's corpse to education in life-saving skills if the resuscitation is unsuccessful). Answering this complex societal question, though, goes well beyond the scope of this paper or of medical practitioners alone.

Common Alternatives

When not using the newly dead to practice and teach these procedures, clinicians commonly use animals—often dogs or pigs. These undoubtedly represent poor models since they only minimally represent human anatomy and pose little difficulty for many procedures, including intubation. Even more common is the use of mannequins. While some sophisticated mannequins seem to be successful at giving trainees at least a rudimentary intubation experience, and virtual-reality models may make the whole question of practicing or teaching any medical procedure using either living or dead bodies moot in twenty years, adequate models do not now exist in most locations. Those that do exist, when available to clinicians, again poorly represent the human form. So how do many clinicians learn their skills? Many learn and practice on unsuspecting patients undergoing general anesthesia. Unlike cadavers, these are live patients who can, and not infrequently are, harmed by a neophyts' practice. This common scenario can only be considered abhorrent, given the availability of bodies who can no longer be harmed.

A Prescription For Clinicians Needing Life-saving Skills

All of the above leads me to the conclusion that those clinicians who need to learn or keep current in life-saving medical skills to decrease their patient's morbidity and mortality not only may—but must—use the newly dead to practice and teach. Artificial barriers must not preclude this. Beneficence—doing good for the (next living) patient—must be the clinician's guiding principle. By doing this, I will never again have to hear a colleague say, "If I had just been a little better at intubation, she would still be alive."

Conclusion

Good ethics begins with good information—in policy development as well as clinical consultations. While information about the disposition of corpses has been difficult to obtain in the past, it is now easily available.

While societies should respect their dead, the living should never be sacrificed to their memory. Difficult life-saving skills in medicine, as in other fields, must not only be taught, but also be constantly practiced and refined. Putting any barriers in the way of physicians practicing and upgrading their skills in performing endotracheal intubation threatens the lives of their future patients. The guise of patient (surrogate) autonomy is stretched thin when ethicists use it to cover postmortem practice and teaching, especially that which is rapid, non-disfiguring, and potentially life-saving for others. (Perhaps we should first concern ourselves with ensuring patient autonomy for the living, who can still be affected by decisions). The common alternatives—practicing and teaching on animals (a poor model) or unsuspecting patients under general anesthesia—can only be considered abhorrent, given the availability of bodies who can no longer be harmed.

While pedants, far removed from the tumult of emergency care, worry over unusual permutations of solid ethical issues, I will encourage my colleagues to continue practicing and teaching, ad lib, on the newly dead. I submit that doing this is not only permissible, it is required. For health professionals to lack needed life-saving skills even once violates the most basic ethical principles.

Little Red Riding Hood unmasked the deception, discovered her peril, and avoided harm. Would that our society will do likewise.

REFERENCES:

[1] Hallett, M. and B. Karasek. *Folk and Fairy Tales*. Ontario, Canada: Broadview Press, Ltd., 1991, 13-15.
[2] Iserson, K.V., *Death to Dust: What Happens to Dead Bodies?* Tucson, AZ: Galen Press, Ltd., 1994.
[3] Perkins, H.S. and A.M. Gordon, "Should Hospital Policy Require Consent for Practicing Invasive Procedures on Cadavers? The Arguments, Conclusions, and Lessons from One Ethics Committee's Deliberations," *Journal of Clinical Ethics* (1994): 3: 204-10.
[4] Iserson, K.V., "Postmortem Procedures in the Emergency Department: Using the Recently Dead to Practice (sic) and Teach," *Journal of Medical Ethics* (1993): 19: 92-98.
[5] Iserson, *Death to Dust: What Happens to Dead Bodies?* 99.
[6] Feinberg, J., "The Mistreatment of Dead Bodies," *The Hastings Center Report* (1985): 31-37.
[7] Iserson, K.V. *Death to Dust*, 182-215.
[8] Iserson, K.V., "Requiring Consent to Practice and Teach Using the Recently Dead," *Journ. Emerg. Med.* (1991): 9:509-10.
[9] Iserson, K.V., "Using a Cadaver to Practice and Teach," *Hastings Center Report* (1986):16:28-29.
[10] Iserson, "Postmortem Procedures," 92.
[11] Callahan, J.C. "On Harming the Dead," *Ethics* (1987):1:341-52.
[12] Iserson, "Postmortem Procedures," 92.
[13] Colpart, J.J., Noury, D., Cochat, P., Kormann, P. Moskovtchenko, J., "Organisation de la Transplantation D'Organes en France," *Pediatrie* (1991):46:4:313-22.
[14] Iserson, K.V., *Death to Dust*, 182-215.
[15] Iserson, K.V., "Law v. Life:The Ethical Imperative to Practice and Teach Using the Newly Dead Emergency Department Patient," *Annals of Emergency Medicine* (1995);25:1:91-94.
[16] Iserson, K.V., *Death to Dust*, 98.

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You Can't Always Get What You Want

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Remind yourself of the opening scene in "The Big Chill." You see an open coffin and a youthful corpse, and hear The Rolling Stones sing the following lyric: "You can't always get what you want, but if you try real hard, sometimes you can get what you need." That's my theme today: medical personnel cannot legally or ethically use the newly dead without the prior consent of the dead person, or the concurrent consent or assent of the next of kin. I will also suggest several legal and ethical approaches to get what is needed. I hope to concentrate on the latter positive arguments to offer what may meet the medical professional's basic need, if not full desires.

First of all, we need to get the terms straight. Presumed consent is an oxymoron and a "concept" that is particularly out of step with today's world. I hope it will suffice to say that presumed consent is what caused Senator Packwood to resign from the Senate before he was expelled. A medical professional must obtain a consent for any medical touching, and this consent must be voluntary and informed. There are exceptions to this common law requirement of consent, but all the exceptions require an immediate and essential benefit to the individual for whom a consent is implied or given by proxy.

But enough of that, because this is not an argument about consent, presumed, waived or deferred, or any other of the recent and usually illegitimate attempts to escape the legal requirement to obtain permission before touching the body or property of another. What Dr. Iserson favors is not to presume a consent for the use of the newly dead to practice medical techniques, but the elimination altogether of the need for any kind of consent to use the newly dead for these purposes. If we agree with Dr. Iserson's proposal, consent is not waived by the family members, nor is consent "deferred" until a later time. No one is asked before the corpse is used; no one is told after the corpse has been used. The use of the corpse is the secret of those who do it and who defend it on the basis of utility and beneficence: it is essential that those who practice emergency medicine hone their skills in order to save the lives of future patients.

Before I list my reasons for arguing that this practice is illegal and unethical, I have two more preliminary claims or arguments, in addition to the caveat that we are not arguing here about any kind of a consent. The second of my three preliminary points is that, if the need for a consent for this practice were eliminated, the use of living, unconscious patients to teach and to learn these techniques would not be eliminated or even reduced, or so my colleagues on medical school faculties inform me. The newly dead in emergency rooms would not be used to teach techniques, but rather to practice and increase skills already taught.

My third preliminary argument is that those emergency techniques that are noninvasive or only minimally invasive, such as intubations and the placement of central venous access lines—techniques that usually leave no evidence that they have been performed, are by no means the only emergency medical procedures that ought to be practiced and kept up to date. Emergency medical personnel ought also to practice and perfect, for example, thoracotomies and pericardiocenteses. Additionally, all of these techniques and procedures need to be practiced "for speed." What is needed is a law or policy or permission that permits emergency medical personnel to practice whatever life-saving techniques need practice, including techniques that are not "hidden," that leave physical evidence. Dr. Iserson and others are not advocating practicing these more invasive techniques without consent, apparently in part because they do leave evidence on the newly dead body. I plan to propose a policy that would permit all these techniques to be practiced in some cases without an immediate consent from those family members responsible for the newly dead body, but for now I repeat that what is needed is a policy that permits emergency medical personnel to practice all the techniques they use to save lives.

Before I turn to a discussion of how we might get what is needed, let me offer, briefly, three reasons why I contend that it is unethical and illegal to use the newly dead for practicing any technique or procedure without a permission, consent, or assent from a next of kin: (1) consent is a legal requirement; (2) our society does not condone imposed altruism, at least not privately imposed altruism; and (3) the next of kin have the primary legal right to control and the legal responsibility to take care of the body of their former family member.

I have already referred to the first of these reasons: medical touchings of all kinds—in fact all touchings of the person or property of another without permission—are often crimes and always a private wrong or tort, an injury that entitles the injured to sue for financial compensation. Involuntary touchings are excepted and so are touchings when life is immediately imperilled, but the common law has never offered an exception that would permit touchings that do not offer a potential benefit to the person or thing touched. To authorize the use of the newly dead in order to provide a societal benefit would be legally innovative, but not legally impossible. What is legally impossible is for those who

desire such a presumption privately to make that presumption and enforce it. Society must authorize a presumed consent and must do so publicly. Emergency room personnel cannot legally or ethically make a private presumption as to the permission, either of the corpse itself or those family members responsible for the corpse.

Just as there is a legal basis for arguing that a presumed consent to use the newly dead is illegal and unethical, so there is a societal basis. Our society's tradition of self-determination and voluntariness is fundamental to our understanding of who we are. We are not a communitarian society; we protect our individual freedoms with zeal. We are even affronted with suggestions that there be a quid pro quo for the receipt of public charity. This attachment to self-determination extends beyond our lives. We can say, albeit within limits, what is to be done with our bodies after death. Hugely rich individuals, even if they can't take it with them, can leave it to their cats and not their prodigal offspring. Testamentary provisions cannot be overturned because they are silly, or because society would benefit greatly from a different distribution of assets.[1] Nonetheless, what our society embraces can change. Laws that permit specified uses of the newly dead would be constitutional, particularly if they provide an exception for those members of society who explicitly object to such use. I will return to this possibility later, but recollect that brain death legislation falls into this category; and, if you live in New Jersey, there is a specific exception for individuals whose religious beliefs oppose the concept of brain death.

Finally, there is a personal or familial basis for the argument that using the newly dead without consent is illegal and unethical. Family members have substantial responsibilities and somewhat less substantial rights concerning the remains of their family members, both the newly dead and the never alive. I turn here from Senator Packwood to your closer neighbors in Orange County. Human ova are not persons or even potential persons, but they are very personal property indeed. The physicians who evidently "presumed" the consent of the ova donors "presumed" that those from whom the eggs were harvested were altruistic and willing to aid others afflicted with infertility, were simply unacceptably, unethically, and illegally presumptive. Using a dead body, touching a dead body, invading a dead body, or using a body part—all require consent. Autopsies require consent; cadaver organ donation requires consent; cadaver tissue donation requires consent; cadaver egg and sperm donation require consent; using a cadaver to teach anatomy or pathology requires consent; and so does using a cadaver to practice medical techniques. There are some exceptions, such as state legislation permitting the excision of corneas from cadavers required by law to undergo autopsy, but these exceptions are all explicitly permitted and ordered by specific legislation. [2]

To recapitulate: why it is illegal and unethical to use the newly dead without permission from the next of kin? It is a touching of the property of another without consent, thus a conversion of property, a battery of the body, and a potential assault on those responsible for the bodily remains.[3] The unconsented use of a corpse violates our society's fundamental belief in self determination and fundamental distaste for imposed obligations. In the United States, obligations are specified, and explicit: individual freedom and autonomy is what is presumed, not duties to others or to society at large.

Before I turn to some positive suggestions, I want briefly to discuss the contention that it is insensitive to ask family members to consent, and that these same family members, sitting in the emergency waiting room anxiously awaiting news of the patient's survival, really are aware that the corpse of their family members may be being used to practice medical techniques before or just after the family is told of the patient's death. First of all, it is not insensitive to request the assent of family members. To do so acknowledges the family's responsibility for the corpse and allows for a true substituted judgment based on the values of the former person. Secondly, this practice is not generally known and accepted. Try it out at your next family dinner, or any gathering where at least a majority of the people are not medical professionals. When I've done just this, the response has always been: "They can't do that." At the same time, after some conversation, most people would permit their own bodies and those of their family members to be so used, but they want to be asked and to give permission. Lastly, research has demonstrated that permission is indeed forthcoming in more than 70 percent of the cases where a consent to use a newly dead corpse has been sought.[4]

I hope I have convinced at least some of you that using the newly dead, without the permission of family members, to practice even the most minimally invasive medical procedures and techniques is illegal and unethical. Even if I haven't, I assume that you would support a plan that would make less problematic the use of the newly dead without specific consent. I propose three potential solutions: new legislation, new institutional policy, and an expanded interpretation of an existing law and policy.

My first suggestion is to pass legislation permitting organ donation and the use of the newly dead in every case where the newly dead person did not previously and explicitly object to such use. This form of legislative presumed consent works reasonably well in many European countries.[5] This legislation would change, as well as expand, the current federal policy of a "required request" for organ donation in the absence of an organ donor card. The legislation I am proposing would make consent presumptive but not obligatory, and would include the use of the newly dead body to teach or to prac-

tice essential emergency medical techniques without explicit permission or even a requirement that the next of kin, if available, be informed. A less innovative legislative change would be what is known as a required response law. This law would require every one who obtains a driver's license to state whether or not he or she is a potential donor of organs or body for teaching and practice.

I know that none of these suggestions, and none that I will make, will cover the infant and child. I can offer you no suggestion that would overcome the need to obtain a proxy consent for the use of a dead infant or child. As I mentioned before, a sensitive approach to the family members has been demonstrated to be successful.[6] I suggest an approach that emphasizes the beneficence of the act and responds to the best part of the former person's values and lifestyle. Do not premise your request as if it were the decision or the responsibility of the surviving family members. If you make the request of a family member, you emphasize that person's responsibility for this newly vulnerable former relative and are more likely to get a negative response. To authorize an invasion of the helpless corpse seems like a repudiation of the responsibility to protect and care for the corpse. Instead, ask for a "consent" from the former person framed as a substituted judgment, a request for a consent that emphasizes the generosity of the former person: would your relative want to help others live in this small but extremely important way? Everyone wants to think well of the dead. All of us want to be useful, but none of us wants to be "used" without our consent or knowledge, even after death.

There are also some possibilities that do not require legislation. This is helpful because our state legislatures have shown that they are loathe to consider, much less to pass, presumed donation or required response legislation. One such possibility is an announced institutional policy. Patients who enter university medical centers know and are told that their caretakers will include medical students and resident physicians. The more savvy of these patients know that they, conscious and unconscious, may well be used by attending physicians, residents, and medical students to teach, to learn, and to practice medical techniques. This is a public, acknowledged practice. Even if it is not often explicitly explained to each patient at a university medical center, it is included in written consent to treatment that each patient must sign. It is difficult, but not unacceptable, to argue that such a policy could be extended to corpses in the emergency room of a university medical center. We presently "imply" the consent of a patient brought to a university medical center emergency room to essential treatment given in part by medical students and resident physicians. I am willing to argue that these patients, if emergency room treatment is not successful, could also be seen by implication to consent to the use of their corpse by medical students and residents. There is an important caveat to this possibility. The policy of permitting the use of the newly dead must be a public, acknowledged, and published policy, one that is at the very least included in the emergency room consent form. In fact, because it is so innovative a policy, I would strongly suggest, were I a legal consultant employed by the institution, that this policy be announced in print in the emergency room.

I have one final suggestion that requires neither legislation nor changes in hospital policy. This is a new argument and I make it very tentatively. I think it would be ethical to conclude that those individuals who have a signed donor card and have consented to the use of their body parts to benefit other individuals have also consented to the practice of emergency medical techniques, including invasive techniques. I also think it is ethical and legal to argue that when a signed donor card is legitimately interpreted to include the use of a body to practice medical techniques, there is no legal or ethical need to obtain an additional consent from a family member. Many medical centers require the permission of the family to harvest cadaver organs even in the presence of a valid donor card. I am morally and legally opposed to such secondary requests. I know survivors can sue, but I also know such suits are not successful. To permit a survivor to countermand the specific consent of the potential donor is to violate the autonomy of the person that was and to take advantage of the defenselessness of the body that is. A donor card should be considered as binding as a testamentary provision.

Perhaps this is only offering crumbs where a whole loaf is desired. I know it is not what those who advocate using the newly dead without consent want, but it may meet the most critical of their needs. I promise you I've tried, as the Stones said, "real hard" to find a legal and ethical way to meet this need.

REFERENCES

[1] Goldblatt AD: "Don't ask; don't tell: Practicing minimally invasive resuscitation techniques on the newly dead." *JACEP* January (1995): 25:86-90.

[2] Goldblatt, op cit.; J.P. Burns, et al., "Using newly deceased patients to teach resuscitation procedures." *New England Journal Medicine* 15 December 1994: 331:24;1652-5.

[3] Burns J.P. et al., op cit.

[4] Benfield DG et al., Letter, *JAMA*, 25 September 1991: 266:1650.

[5] Goldblatt, op cit.

[6] Benfield, D.G., et al., "Teaching intubation skills using newly deceased infants." *JAMA* 1991: 265: 2360-5.

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The faculty for this program explore ethical issues in health care and related fields from Christian perspectives. Students come from a variety of religious and cultural backgrounds. Mutual respect for various cultures and beliefs is emphasized on the campus and in the classroom.

The faculty comprises scholars in biblical and religious studies, biomedical and clinical ethics, sociology of religion, and ethical theory. Four of ten members of the faculty are physicians with training and professional experience in clinical ethics.

The Center for Christian Bioethics at Loma Linda University possesses an extensive bioethics library. The Center sponsors monthly Bioethics Grand Rounds which feature guest speakers and address current issues in medicine and ethics.

E-Mail: gwinslow@ccmail.llu.edu
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MA in Clinical Ministry

The Master of Arts in Clinical Ministry is designed for three types of students: those seeking to pursue graduate studies in ministry; those wishing to enhance already existing careers with graduate study in religion; and those wishing to use this degree as a stepping stone to doctoral study.

This degree furthers the educational process of caring for the whole person through the development of clinical skills. It blends two major areas of concentration: academic preparation and clinical experience.

The faculty represent a balance between academic expertise and clinical experience, as well as a variety of disciplines including biblical studies, theology, practical theology, marriage and family therapy, cultural psychology, American church history, health education, and ethics.

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For more information on either of these programs, send your request to:

Center for Christian Bioethics
Loma Linda University
Griggs Hall, Room 221
Loma Linda, CA 92350

Be sure to visit our Web sites:
for Clinical Ethics:
http://www.llu.edu/llu/bioclineth.htm

for Clinical Ministry:
http://www.llu. edu/llu/fr/clinmin.html

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